JCN Journal of Clinical Nursing

Journal of Clinical Nursing

ORIGINAL ARTICLE

Nursing and medical students' attitude, knowledge and beliefs regarding lesbian, gay, bisexual and transgender parents seeking health care for their children

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Background. Little research has been conducted to investigate students' attitudes, knowledge and beliefs regarding lesbian, gay, bisexual and transgender parents seeking health care for their children.

Design. Descriptive, comparative study. Validated scales were used to assess students' attitudes, knowledge and beliefs and gay affirmative practice. Three open ended questions assessed beliefs regarding lesbian, gay, bisexual and transgender parents accessing health care for their children.

Method. Nursing and medical students completed questionnaires about attitudes to homosexuality. Associations between variables were assessed using chi-square tests of independence, and differences between nursing and medical student groups were assessed using the Mann–Whitney *U*-test or the Kruskal–Wallis one-way analysis of variance test. Responses to the open ended questions were evaluated, coded and described.

Results. Knowledge and attitudes about homosexuality were significantly associated with students' race, political voting behaviour, religious beliefs and having a friend who is openly lesbian, gay, bisexual and transgender.

Conclusions. It is important to develop strategies to address the existence of prejudicial attitudes among student health professionals and prevent discriminatory practices towards lesbian, gay, bisexual and transgender parents when seeking health care for their children.

Relevance to clinical practice. Educators can develop programs that provide students with knowledge and skills to ensure lesbian, gay, bisexual and transgender families receive effective health care when they access services for their children.

Key words: attitudes, bisexual and transgender families, gay, homosexual, lesbian, medical, nursing, students

Accepted for publication: 7 June 2011

Introduction

Parenting by lesbian, gay, bisexual and transgender (LGBT) persons is increasingly common (Perrin *et al.* 2004, Telingator & Patterson 2008); however, the exact number of these families is unknown because many LGBT parents are reluctant to disclose their sexual identity (Neville & Henrickson 2009). Homophobia, the fear and dislike of LGBT people; and heterosexism, the belief that heterosexuality is the norm and should be taken for granted, are common and are major barriers to receiving and providing quality health care to LGBT persons

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doi: 10.1111/j.1365-2702.2011.03892.x

(Klitzman & Greenberg 2002, Neville & Henrickson 2006, 2009).

Lesbian, gay, bisexual and transgender persons continue to have negative experiences with health care professionals (Gold *et al.* 1994, Hinchliff *et al.* 2005, Polek *et al.* 2008) including encountering homophobia and the delivery of unsatisfactory treatment (Klitzman & Greenberg 2002, Neville & Henrickson 2006, 2009). As a result, LGBT people can be reluctant to disclose their sexual identity when seeking health care services and may not access health care for themselves and their families (Garcia 2003, Perrin *et al.* 2004, Polek *et al.* 2008, Neville & Henrickson 2009).

Nursing and medical educators prepare students to provide care for all people in a non-prejudiced and inclusive way (McKelvey *et al.* 1999). This philosophy is especially significant for LGBT parents and their families. However, nursing and medical curricula pay little, if any, attention to non-heterosexual aspects of care despite research which demonstrates that students frequently demonstrate negative attitudes and low knowledge regarding LGBT people (McKelvey *et al.* 1999, Röndahl *et al.* 2004, Logie *et al.* 2007).

Poor knowledge and negative attitudes toward LGBT people have been closely related to students' gender, ethnicity, religious beliefs, level of education and political views (McKelvey *et al.* 1999, Röndahl *et al.* 2004, Logie *et al.* 2007). However, we were unable to find any research that investigated students' attitudes, knowledge and beliefs toward LGBT parents seeking health care for their children. Because of this paucity of literature, we aimed to describe the attitudes, knowledge and beliefs of nursing and medical students towards LGBT persons and towards LGBT parents seeking health care for their children, and to identify differences in attitudes, knowledge and beliefs by sociodemographic characteristics. This information will assist educators to develop education programs that ensure LGBT families receive equitable, high quality, holistic health care.

Methods

A self administered questionnaire was used to collect quantitative and qualitative data from a sample of medical and nursing students in Western Australia between May and August 2010. A convenience sample of all 150 nursing students in their third year of study at one university, and all 171 medical students who had completed their 5th year at another were recruited by members of the research team. All had completed their paediatric clinical placement and therefore had experience in caring for children and their parents.

Anonymous questionnaires were distributed at the completion of a lecture for both student groups, and a self-addressed envelope provided for return. Consent was implied on return of the questionnaire. Ethics approval for the study was gained from the human research ethics committees of both universities.

Questionnaire

The questionnaire collected basic sociodemographic data and assessed whether students had ever cared for a child from a LGBT family, and whether they had friends who were openly LGBT. Three published scales were used to evaluate knowledge about homosexuality, attitudes towards lesbians and gay men, and the consistency of their beliefs with gay affirmative practice. All three scales have consistently shown high levels of internal consistency and have established construct validity (Herek 1994, 1995, Herek & Capitanio 1995, Harris *et al.* 1995, Harris & Vanderhoof 1995, Crisp 2006).

We were unable to locate published scales that collectively assessed attitudes to and knowledge about the broader construct of LGBT persons that were appropriate for use in this study, and that had established psychometric properties. As such, three open ended questions were also included in the questionnaire to identify participants' thoughts, feelings and beliefs regarding LGBT parents accessing health care for their children. The open ended questions included: When taking a family social history, do you specifically encourage disclosure of possible LGBT parenting roles? What are the implications, if any, for health care provision for a child if his or her LGBT parents do not disclose their relationship? What suggestions do you have that might assist health professionals to care for/manage children of LGBT families?

We used the Knowledge About Homosexuality Scales developed by Harris (1995) to measure the accuracy of students' knowledge about issues related to sexual orientation. The scale requires participants to correctly identify a series of 20 statements as true or false, with a higher score indicating a greater level of knowledge. Item 18 of the scale, which refers to the founding of the 'National Gay and Lesbian Task Force' was excluded from the scale in this study due to its limited relevance in Australia.

The 20-item Attitude Toward Lesbians and Gay Men Scale (Herek 1994) using a four point Likert scale was used to assess students' attitudes towards lesbian and gay men. Participants were asked for level of agreement with statements evoking affective responses to homosexuality and to gay men and lesbians. Scale scores assess overall attitudes to lesbians and gay men, and the two subscale scores attitudes

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to lesbians and gay men separately, although subscale scores cannot be directly compared (Herek 1994). Higher scale scores indicate more negative attitudes.

The 15-item Gay Affirmative Practice Scale also used a four point Likert scale to assess the degree to which students' beliefs about clinical practice are consistent with gay affirmative action (Crisp 2006), with a higher score indicating practice beliefs that are more consistent with gay affirmative action principles.

Data analysis

Data were entered into SPSS version 17.0 for analysis after auditing data entry quality using a random 10% sample of returned questionnaires. Due to the highly skewed nature of the attitude and gay affirmative practice scores, we tested associations between variables using the chi-square tests of independence, and differences between nursing and medical student groups using the Mann–Whitney *U*-test or the Kruskal–Wallis one-way analysis of variance test. Spearman rank correlation coefficients were used to describe correlation between continuous variables. Responses to the open ended questions were read line-by-line and significant words and phrases identified and coded based on the major thrust or intent of each response (Speziale-Streubert & Carpenter 2003).

Results

One-hundred-and-sixty-one medical and 100 nursing students completed questionnaires (response rate 81·3%). Table 1 shows sociodemographic characteristics by student group. The mean age of nursing students' (23·8 years, range 19–50 years) was significantly different to the mean age of medical students (24·7 years, range 21–46 years, $U = 3860$, $p < 0{\cdot}001$). The sample was largely female and heterosexual, with four respondents self-identifying as bisexual and no respondents self-identifying as lesbian or gay. Student group was significantly associated with gender ($\chi^2 = 30{\cdot}9$, df = 1, $p < 0{\cdot}001$), Caucasian race ($\chi^2 = 10{\cdot}7$, df = 1, $p = 0{\cdot}001$) and highest qualification ($\chi^2 = 30{\cdot}9$, df = 1, $p < 0{\cdot}001$), with nursing students more likely to be female and Caucasian, and less likely to have a university degree compared with medical students (Table 1).

Table 1 Sample sociodemographic characteristics* by student group

Characteristic	Nursing students (n = 100), %	Medical students (n = 161), %	Total sample (n = 261), %
Gender			
Female	94	66·3	76·9
Male	6	33·7	23·1
Highest qualification			
Year 12	63·5	68·3	66·5
Diploma	21·9	2·5	9·7
University degree	14·6	29·2	23·7
Marital status			
Single	53·1	57·8	56
Married	11·2	8·7	9·7
Other	35·7	33·5	34·4
Sexual orientation			
Heterosexual	99	97·5	98·1
Bisexual	1	1·9	1·6
Other	0	0·6	0·4
Race			
Caucasian	76	56·3	63·8
Asian	20	40·6	32·7
Other	4	2·5	3·5
Religion			
Not religious	50·5	47·2	48·5
Christian	42·4	40·4	41·2
Other	7·1	12·4	10·4
Religious service attendance			
Weekly or more	20	24·2	22·6
Less than weekly	80	75·8	77·4
Political voting behaviour			
Liberal	24	32·9	29·5
Labour	33	32·9	33
Greens	14	13·7	13·8
Other	29	20·5	23·7
Ever cared for LGBT family			
Yes	8·4	3·8	5·5
Unsure	18·9	20·1	74·8
No	72·6	76·1	19·7
Friends who are openly LGBT			
Yes	77·7	77·2	77·4
No	22·3	22·8	22·6

*Valid per cent.

Knowledge, attitudes and gay affirmative practice beliefs

Table 2 shows mean knowledge, attitude and gay affirmative practice scores by sociodemographic characteristics and student group. Of the 19 knowledge statements, 13% nursing and 38% of medical students identified 17 (90%) or more statements correctly. Knowledge scores were significantly associated with race, political voting behaviour, religious beliefs, the frequency of attendance at religious services and having a friend who is openly LGBT. As shown in Table 2, Caucasians, supporters of less conservative political parties, those who reported no religious beliefs, those who reported not attending religious services weekly and those who had a friend who is openly LGBT had significantly higher knowledge scores.

Table 2 Knowledge, attitude and gay affirmative practice mean scale score comparisons* by sociodemographic variables and student group

Scale	Knowledge, mean (SD)	*p*	Attitudes, mean (SD)	*p*	Gay affirmative practice, mean (SD)	*p*
Gender						
female	14·9 (2·5)	0·62	29·6 (10·3)	0·01	54·2 (7·4)	0·08
male	15·2 (2·3)		34·3 (12·9)		52·7 (7·0)	
Marital status						
single	14·8 (2·5)	0·19	31·6 (12·1)	0·52	53·3 (8·3)	0·5
other	15·3 (2·3)		29·8 (9·9)		54·6 (5·7)	
Race						
Caucasian	15·5 (2·2)	< 0·001	27·5 (8·5)	< 0·001	53·7 (7·7)	0·97
other	14·0 (2·6)		36·8 (13·0)		53·9 (6·6)	
Political voting behaviour						
liberal	15·1 (2·1)	< 0·001†	31·3 (10·3)	< 0·001†	53·2 (7·0)	0·07†
labor	15·3 (2·6)		27·8 (8·3)		54·3 (7·2)	
greens	15·9 (2·1)		25·6 (5·7)		55·9 (6·1)	
other	14·0 (2·6)		36·9 (14·7)		52·7 (8·4)	
Religious beliefs						
yes	14·7 (2·4)	0·02	33·2 (12·8)	0·008	53·5 (7·4)	0·44
no	15·3 (2·4)		28·1 (8·4)		54·2 (7·2)	
Attend religious service						
weekly+	13·8 (2·5)	< 0·001	44·4 (13·8)	< 0·001	51·7 (7·7)	0·03
< weekly	15·4 (2·3)		27·3 (6·9)		54·4 (7·1)	
Highest qualification						
< degree	14·9 (2·4)	0·09	30·5 (11·2)	0·35	54·2 (7·5)	0·046
degree+	15·4 (2·4)		31·3 (10·9)		52·7 (6·9)	
Friends openly LGBT						
yes	15·3 (2·2)	0·001	28·2 (8·7)	< 0·001	54·7 (6·7)	< 0·001
no	14·1 (2·7)		39·0 (14·5)		51·3 (7·2)	
Ever cared for LGBT child						
yes	14·5 (2·8)	0·49	27·6 (6·8)	0·54	55·7 (6·4)	0·28
no	15·0 (2·5)		31·5 (11·7)		53·6 (7·2)	
Student group						
nursing	14·0 (2·6)	< 0·001	30·2 (10·8)	0·46	55·0 (8·6)	0·001
medical	15·6 (2·1)		31·1 (11·4)		53·1 (6·5)	

*Mann–Whitney *U*-test.
†Kruskall–Wallis one-way ANOVA.
SD, standard deviation.
Higher knowledge scores indicate greater knowledge (possible range 0–19).
Higher attitude scores indicate more negative attitudes (possible range 20–80).
Higher gay affirmative practices indicate greater consistency with gay affirmative practice (possible range 15–60).

Attitudes also differed significantly according to sociodemographic characteristics, including gender (Table 2). Differences found in overall attitude scores by sociodemographic characteristics represented significant differences in attitudes to both lesbians and gay men, apart from differences according to gender. The overall significant difference in attitudes according to gender reflected only a significant difference in attitudes towards gay men ($U = 3272$, $p = 0{\cdot}001$) and not attitudes towards lesbians ($U = 4478$, $p = 0{\cdot}10$). Males had significantly more negative attitudes towards gay men (mean subscale score 19·1) compared with females (mean subscale score 15·9). For example, this finding is illustrated by the responses to two of the attitude scale items that relate directly to attitudes toward lesbian and gay parenting. Overall 16·5% of respondents (16·9% of females and 15·3% of males) agreed that lesbians should not become parents, and 30·4% (25·5% of females and 46·7% of males) did not believe that male homosexuals should be able to adopt.

For the Gay Affirmative Practice (GAP) scale, 30·7% of respondents received the maximum scale score which is consistent with gay affirmative practice, and almost 75% scored 50 or more out of possible 60. There was only a weak positive correlation between knowledge scores and GAP scores (Spearman rank $r = 0{\cdot}18$, $p = 0{\cdot}006$). GAP scores were

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more strongly associated with attitudes, with a moderate negative correlation between GAP scores and attitudes (Spearman rank $r = -0{\cdot}41$, $p < 0{\cdot}001$). There was also a moderate negative correlation between attitude and knowledge scores (Spearman rank $r = -0{\cdot}42$, $p < 0{\cdot}001$).

Beliefs about LGBT parents seeking health care for their children

Participant responses to the three open ended questions elicited beliefs about caring for children from LGBT families. When asked if they specifically encouraged disclosure of possible LGBT parenting roles when taking a family social history 193 students (73·9%) responded to the question. Among respondents 58 (30·1%) encouraged the disclosure of possible LGBT parenting roles, 79 (40·9%) reported that they did not specifically encourage the disclosure of possible LGBT parenting roles, and 56 (29·0%) indicated neither agreement nor disagreement with encouraging disclosure of possible LGBT parenting roles.

The five most frequent explanations for not encouraging disclosure were that LGBT parenting roles were not relevant or important, that it was up to the parents to disclose, that it was a personal issue or questioning was too intrusive, that they had not previously thought of encouraging disclosure, and that they had not had a relevant patient encounter. Respondents who encouraged disclosure of LGBT parenting roles believed that it provides important, relevant and useful information for the delivery of appropriate health care; reported that gender neutral language including 'parent' and 'partner' and open ended questioning such as 'who lives at home?' formed the basis of their strategy to facilitate open communication; and that disclosure was led by and up to the parent.

Respondents who neither agreed nor disagreed with encouraging disclosure of possible LGBT parenting roles predominantly indicated that they would encourage disclosure only if it was clinically relevant, and that it was up to the parents to disclose. Five respondents indicated that encouraging disclosure risked offending patients, with perceptions that 'the risk of offending heterosexual patients was greater than the benefit of connecting with LGBT patients.' One participant responded that 'God says it is wrong!!!'

When asked to identify the implications for health care provision of parental nondisclosure of LGBT relationships, 147 students (56·3%) responded to the question. The three most frequent responses were that nondisclosure has no implications (40·1%); that families may not get the required treatment and support (29·9%); and that poor communication, confusion, embarrassment, isolation and stress may result (18·4%).

When asked for suggestions that might assist health professionals to care for children of LGBT families, 141 students (54·0%) responded to the question. The three most frequent responses indicated the importance of being open-minded, non-judgmental and respectful (37·6%); the need for increased awareness and understanding among health professionals, including the need for educational interventions to improve awareness and understanding (36·2%); and the need to provide resources and better support systems for health professionals, parents and patients (8·5%). One respondent indicated the need to 'put policy in place that does not allow LGBT parents to have children'.

Discussion

An extensive literature search failed to find studies investigating nursing and medical students' attitudes, knowledge and beliefs (AKB) about LGBT parenting or their interactions with these families. This current study is the first to focus on the AKB of medical and nursing students toward LGBT persons and their parenting role, which are known to impact on the delivery of health care to LGBT families (Mikhailovitch *et al.* 2001, McNair *et al.* 2008). Overall student knowledge was poor, and in the case of nursing students only 13% identified 90% or more statements correctly. In addition, 16·5% of the students considered that lesbians should not become parents and 30·4% did not believe that gay men should be able to adopt.

There were significant differences in students' AKB towards homosexuals according to sociodemographic characteristics such as race, political voting behaviour, religious beliefs, frequency of attendance at religious services and having a friend who is openly LGBT. These relations are consistent with findings among other population groups (McKelvey *et al.* 1999, Röndahl *et al.* 2004, Sanchez *et al.* 2006). Although only half of the participants self-identified as religious, a high proportion of these respondents (23%) attended a religious service weekly or more, which may explain our finding of significant differences in AKB towards homosexuals according to both religious beliefs and practices.

Significant differences in knowledge, attitudes and gay affirmative practice beliefs according to religious beliefs and practices indicate the considerable potential influence of personal values on health service provision. It was beyond this study to explore relationships between the questionnaire responses and the actual interactions our students had with clients. However, students who hold negative attitudes toward LGBT people may be less likely to provide an environment where clients feel safe to disclose their sexual

orientation or an environment where they are encouraged to seek health care for themselves or their children.

Ethnicity plays an important role in moulding personal views and beliefs. We found significant differences in AKB according to respondent's racial background. For example, students who identified as non-Caucasian demonstrated poorer knowledge and had more negative attitudes towards LGBT people than Caucasian students. Australia is a multicultural society and although a large proportion of our students were Caucasian, we did not ask if they were born in Australia. The potential influence of a student's country of birth on these findings is unclear and must be considered when interpreting our results.

Previous studies have found that race and ethnicity had a negative effect on attitudes and knowledge (McKelvey *et al.* 1999, Röndahl *et al.* 2004, Sanchez *et al.* 2006). This finding is important because students who come to Australia from different cultural backgrounds may be reluctant to adopt new beliefs and practices (Röndahl *et al.* 2004). It is imperative that educational institutions provide programs that are appropriate for the diverse cultural backgrounds of their students. This includes the provision of culturally sensitive education and training to enable students to deliver equitable and non-prejudiced care to LGBT clients and their families.

Although medical students had a significantly higher level of knowledge about homosexuality, their gay affirmative practice scale scores were significantly lower than those of nursing students, possibly reflecting differences in their gender, race and educational background. Females have also been shown to hold a more positive attitude toward LGBT patients than their male counterparts, as demonstrated in this study and elsewhere (Sanchez 2006, Shindel *et al.* 2010). This finding may also be related to male participants' endorsement of traditional sex roles which are linked to socialisation pressures, concepts of masculinity, and the equality of men and women (Kurdek 1988). However, determining the source of these differences in attitudes was beyond the scope of our study and requires further epistemological research.

Having friends who are openly LGBT was an important correlate of knowledge, attitudes and gay affirmative practice beliefs, and such factors could be used to inform the development of communication and education strategies to promote less prejudicial attitudes among student health professionals. Having friends, family or previous clinical contact with people who are openly LGBT has been shown to increase student comfort to discuss a client's sexual orientation, lifestyle and health issues (Sanchez 2006, Shindel *et al.* 2010). It is imperative that strategies be developed that promote opportunities for students to participate in groups to share thoughts, feelings and concerns related to caring for LGBT clients and their families. In this way those students with less tolerant attitudes may be moved from judgment to empathy and then be in a position to provide more effective care (McKelvey *et al.* 1999).

The students in our study demonstrated high GAP scores, suggesting that our respondents are committed to culturally competent practice with LGBT people (Crisp 2006). However, findings from the open-ended questions do not support this observation. Less than a quarter of the students reported encouraging clients to disclose their LGBT parenting roles, with other respondents believing that the information was not relevant to their care or the question was too intrusive. As our participants are still students of their chosen fields and not clinicians, their interactions and practice with LGBT persons are, in the main, still untried. It was beyond the scope of this study to observe student interactions with LGBT clients and future research is required to establish if there is an association between theoretical or considered AKB and actual practice.

The family centred care (FCC) model of clinical care delivery provides a framework that can promote the delivery of inclusive, quality health services to LGBT families. FCC requires health professionals to demonstrate respect for all families regardless of the family structure (Ahmann 1999, Shields *et al.* 2006), and is widespread across curricula for nursing students. However, our findings indicate that the teaching of clinical care delivery to medical and nursing students requires review to ensure that it embraces the diversity of family structures in the Australian community and does not exclude potentially vulnerable LGBT families.

The benefits of a FCC approach can only be realised if health professionals are sensitive to the context, functions, and constructs of every family they encounter. Parents who bring their children for health care need supportive family-centred care, and only by ensuring that the health professionals delivering care are well educated about all aspects of sexuality will care be family-centred. Consultation is critical to the success of the research process and adoption of research outcomes. Therefore, it is imperative that Universities, in consultation with the LGBT community, review nursing and medical curricula to ensure that students are provided with education and training related to all aspects of human sexuality. With this knowledge student health professionals will be better placed to provide non-judgmental and equal care to all families.

Limitations

This study used a convenience sample of students from two educational institutions, which limits the generalisability

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of the findings. Based on the size of the sample studied and the descriptive aim of this research, we chose not to adjust for multiple comparisons. However, due to the number of variables examined and multiple statistical comparisons performed, some statistically significant associations ($p < 0{\cdot}05$) may have been found by chance. Larger studies are needed to overcome this limitation and identify the independent predictors of negative attitudes, lack of knowledge and beliefs that do not support gay affirmative practice. Further work is also required to develop quantitative assessment methods that can provide valid and reliable indicators of the quality of care provided to LGBT families.

Conclusion

Our findings indicate the importance of developing strategies to address prejudicial attitudes among student health professionals and prevent discriminatory practices towards LGBT parents when seeking health care for their children. The consistency of associations between sexual prejudice and sociodemographic characteristics among diverse population groups highlights the omnipresent nature of homophobia and the challenges of eliminating discrimination toward LGBT parents and their families. These findings also highlight the importance of a broad based community approach to the establishment of the values of equality, respect and the prevention of discrimination in health service provision.

Relevance to clinical practice

The findings of this study have identified areas in which students need education and support. Currently little attention is paid to caring for LGBT families within nursing and medical curricula. To ensure LGBT families accessing and seeking health care services receive equitable, high quality, holistic health care, educational institutions must provide programs which prepare students to effectively care for all families irrespective of their sexuality or gender identity. These programs should provide culturally sensitive education and training and offer students opportunities to participate in group activities where they can share their experiences and concerns about caring for LGBT clients and their families.

Acknowledgements

This study is supported by the Nurses Memorial Trust of Western Australia, and Channel 7 Telethon. We thank Ms Anne Bourke, who helped us secure funding, Ms Tracy David with assistance with data entry, and the participants who gave of their time and effort.

Contributions

Study design: RC, LS, RW; data collection and analysis: RC, RW and manuscript preparation: RC, LS, RW, TZ, PN.

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